STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

November 22, 2021

Benneth Okonkwo
Tender Heart Quality Care Services LLC
5083 Bedford Street
Detroit, MI 48224

RE: License #: AS820312395
Investigation #: 2021A0901038
Bedford Home

Dear Mr. Okonkwo:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS820312395
Investigation #:	2021A0901038
Complaint Receipt Date:	09/29/2021
Investigation Initiation Date:	09/29/2021
Report Due Date:	11/28/2021
Licensee Name:	Tender Heart Quality Care Services LLC
Licensee Address:	5083 Bedford Street Detroit, MI 48224
Licensee Telephone #:	(248) 240-4413
Administrator:	Appolonia Okonkwo
Licensee Designee:	Benneth Okonkwo
Name of Facility:	Bedford Home
Facility Address:	5083 Bedford Street Detroit, MI 48224
Facility Telephone #:	(313) 886-2125
Original Issuance Date:	10/22/2012
License Status:	REGULAR
Effective Date:	09/29/2020
Expiration Date:	09/28/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The facility would not take Resident A back when he was ready to be discharged from the hospital.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/29/2021	Special Investigation Intake 2021A0901038
09/29/2021	Special Investigation Initiated - Telephone St. John Hospital Social Work Department
09/29/2021	Contact - Telephone call made Resident A's Guardian
09/29/2021	Contact - Telephone call made Licensee Designee, Benneth Okonkwo
09/30/2021	APS Referral
09/30/2021	Contact - Telephone call made Lakeitha Stevens, Licensing Consultant
10/04/2021	Contact - Document Received Email
10/12/2021	Contact - Telephone call made Case Manager, Valerie Karigosion
10/14/2021	Contact - Telephone call made Resident A's Guardian
10/14/2021	Contact - Telephone call made Case Manager, Valerie Karigosion
10/14/2021	Inspection Completed-BCAL Sub. Compliance
10/20/2021	Contact - Telephone call made Case manager, Valerie Karigosion

10/25/2021	Referral - Recipient Rights
11/15/2021	Exit Conference Licensee designee, Benneth Okonkwo

ALLEGATION:

The facility would not take Resident A back when he was ready to be discharged from the hospital.

INVESTIGATION:

On 09/29/2021, I made a telephone call to St. John Hospital's social work department. I was informed that Resident A was still there, due to no one picking him up. The social work department called the home several times and was told by home's administrator, Appolonia Okonkwo, that they were not taking Resident A back because he needs 1:1 staffing. She stated he requires a lot of attention and they cannot keep everyone safe in the home.

On 09/29/2021, I made a telephone call to Resident A's guardian, Kristin, from Guardian Care, and left a voice message.

On 09/29/2021, I made a telephone call to the licensee designee, Benneth Okonkwo. He confirmed his refusal to pick Resident A up from the hospital. He explained that when Resident A was initially placed there in July 2021, he was temporarily authorized as needing 1:1 staffing. When it was time to renew the authorization, which was 30 days after his placement, it was not renewed. Mr. Benneth stated he continued to provide 1:1 staffing, even though he was not getting paid for it, but can no longer afford to do it.

On 10/12/2021, I made a telephone call to Resident A's case manager form Team Wellness, Valerie Karigosion. There was no answer. I left a voice message.

On 10/14/2021, I made a telephone call to Kristin, from Guardian Care. She stated Mr. Okonkwo never notified her of his concerns about not being able to take care of Resident A because he was not approved for 1:1 staffing. She stated she was not informed of this until notified by the hospital of their refusal to take Resident A back into the home. Kristin stated had Mr. Okonkwo communicated this sooner, she could have intervened in having Resident A re-assessed. She was very upset about the manner in which they discharged Resident A, by abandoning him at the hospital.

On 10/14/2021, I made a telephone call to Resident A's case manager form Team Wellness, Valerie Karigosion. There was no answer. I left a voice message.

On 10/20/2021, I made a telephone call to Resident A's case manager form Team Wellness, Valerie Karigosion. There was no answer. I left a voice message.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**

ANALYSIS:	Based on the information obtained during this investigation, the above licensing rule was not adhered to and Resident A was improperly discharged. The licensee designee refused to allow him back into the home when he was ready for discharge from the hospital. He was abandoned at the hospital instead of being allowed to return to the facility until an appropriate placement was found.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/29/2021, I made a telephone call to the licensee designee, Benneth Okonkwo. He stated he completed an emergency discharge notice on Resident A in August 2021.

On 09/30/2021, I made a telephone call to the licensing consultant for the facility, Lakeitha Stevens. She stated she never received a discharge notice for Resident A.

On 10/04/2021, Mr. Okonkwo sent me a copy of the discharge notice. It was dated for 08/31/2021. There was no documentation on it regarding Ms. Stevens being notified and it indicated that Resident A's guardian and case manager was notified 08/31/2021.

On 10/12/2021, I made a telephone call to Resident A's case manager form Team Wellness, Valerie Karigosion. There was no answer. I left a voice message.

On 10/14/2021, I made a telephone call to Kristin, from Guardian Care. She stated she never received a written discharge notice on Resident A. She also stated she spoke with Mr. and Mrs. Okonkwo on 08/24/2021 and 08/30/2021 and they did not mention anything about not being able to care for Resident A or their intentions of discharging him.

On 10/14/2021, I made a telephone call to Resident A's case manager form Team Wellness, Valerie Karigosion. There was no answer. I left a voice message.

On 10/20/2021, I made a telephone call to Resident A's case manager form Team Wellness, Valerie Karigosion. There was no answer. I left a voice message.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	Based on the information obtained during this investigation, all of the discharge procedures were not followed. A copy of the written notice was not given to the licensing consultant and Resident A's guardian.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

____11/18/2021

Regina Buchanan — Date

Licensing Consultant

Approved By:

____11/22/2021

Ardra Hunter — Date

Area Manager